Iowa Department of Human Services

PAYMENT APPLICATION FOR NONREGISTERED PROVIDERS

Mark Appropriate Boxes: ❑ New ❑ Renewal ❑ PROMISE JOBS Child Care

PLEASE PRINT

Last Name	First	M.	Birth Date
Maiden Name/Other Last Names			Social Security Number
Street Address			Telephone Number ( )
City and State		Zip Code	County

List below the names of other adults and children living in the home. If more space is needed, please use a separate sheet of paper and attach it to the application.

Last Name	First	M.	Birth Date	Social Security Number

I certify that:

1. I have read the minimum health and safety requirements for nonregistered child care homes, and I comply with
   a. Home safety requirements b. Provider requirements c. Number of children requirements
2. I certify that the total number of my own children and child care children not in kindergarten or a higher grade level will never exceed five. There shall never be more than four children under two years of age at any one time.
3. I will allow parents/caretakers unlimited access to their children during hours when care is provided, unless parental contact is prohibited by court order.
4. I understand that the Department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, form 470-3871, if the Department finds a hazard to the safety and well-being of a child, and I cannot or refuse to correct the hazard, or if I have submitted claims for payment for which I am not entitled.
5. I understand that, according to the provisions of Iowa Code Chapter 237A, a person who has been convicted of a crime against a person, or a person with a record of founded child abuse may be restrained by temporary or permanent injunction from providing nonregistered, registered, or licensed child care. The action may be instituted by the state, a political subdivision of the state, or an interested person.
6. I understand that by Iowa law criminal record checks and child abuse registry checks must be completed on all persons living in my home who are 14 years and older in age.
7. I understand that I must complete and sign this form and return it to the department. I also understand that criminal and child abuse record checks will be done and that people who have founded child abuse or criminal convictions are not eligible to receive Child Care Assistance payments.

Signature of Applicant	Date

RIGHT OF APPEAL

If you disagree with any action or failure to act in regard to this notice, you have the right to appeal - 441 Iowa Administrative Code, Chapter 7.

How to Appeal. You must appeal in writing to the Department of Human Services (DHS) office in your county, to your PROMISE JOBS office, or you may submit it directly to the Appeals Section, 5th Floor, Department of Human Services, 1305 E Walnut St, Des Moines, IA 50319-0114. There is no fee or charge for an appeal. Your PROMISE JOBS office will help you file an appeal if you ask them.

Time Limits. To get a hearing you must file your appeal within 30 calendar days or before the effective date of this notice, whichever is longer. When the appeal is later than this but less than 90 calendar days after the date of this notice, the Director of the Iowa Department of Human Services must approve whether a hearing will be held, based on good cause for late filing. If the appeal is filed more than 90 calendar days after the date of this notice, there will be no hearing. Any discussion between you and the worker, the worker's supervisor, or any other Department staff does not extend these time periods.

Continuation of Benefits. If you appeal this action within 10 days or before the effective date of this notice, you will continue to get benefits, unless you ask not to, until the appeal decision is final. Benefits you get while your appeal is being decided may have to be paid back if the DHS action is found to be correct.

Granting a Hearing. The Department of Human Services will determine whether or not an appeal may be granted a hearing. If a hearing is granted, you will be notified of the time and place. If a hearing is not granted, you will be notified in writing of the reason and the procedures for challenging that decision.

A hearing need not be granted if the appeal is not eligible to be heard. Services funded by the Social Services Block Grant (SSBG) are subject to changes or terminations stated in the SSBG Pre-expenditure Report prepared each fiscal year for the period of July 1 to June 30. Such changes are specifically not subject to hearing. There are additional limitations to granting hearings which are explained in 441 Iowa Administrative Code, Chapter 7. If no hearing is granted, you will be notified of the reason.

Presenting Your Case. If an appeal hearing is granted, you may explain your disagreement or have someone else like a relative or friend explain your disagreement for you. An attorney may represent you, but the Department will not pay for the attorney. Your county Department of Human Services office has information about legal services available to you that are based on your ability to pay. You may also phone Legal Services Corporation of Iowa at 1-800-532-1275. If you live in Polk County, phone 243-1193.

POLICY ON NONDISCRIMINATION

This action was taken without regard to race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief. If you think you have been discriminated against for any of the reasons stated above, you may file a complaint with the Iowa Department of Human Services by completing a Discrimination Complaint form, which you can get from any Department of Human Services office or the Department of Human Services Diversity Programs Unit. You may also file a complaint with the Iowa Civil Rights Commission (if you feel you were discriminated against **because of** your race, creed, color, national origin, sex, religion, or disability) or the US Department of Health and Human Services, Office for Civil Rights.

Iowa Department of Human Services
Diversity Programs Unit 1st Fl
1305 E Walnut St
Des Moines IA 50319-0114

Iowa Civil Rights Commission
211 E Maple St
Des Moines IA 50309-1858

US Department of Health and Human Services
Office for Civil Rights Region VII
Federal Building
601 E 12 St Rm 248
Kansas City MO 64106-2808

Agreement Number_____

Iowa Department of Human Services

CHILD CARE ASSISTANCE PROVIDER AGREEMENT

Provider Name		
Address		
City	Zip	Phone
Social Security or Federal ID No.	County	

I agree to participate as a provider of child care services approved by the Iowa Department of Human Services (hereafter 'Department') and/or the PROMISE JOBS program and assure the Department that I will comply with the provisions of this agreement.

ELIGIBLE PROVIDER:

I must meet all federal, state, and local standards that pertain to the child care services being provided under this payment agreement.

I must not assign, transfer, or subcontract any interest in this agreement. That is, no payment for services made under this agreement can go to anyone other than the provider named in this agreement.

CHECK ONE:

- ❑ Licensed Child Care Center
- ❑ Child Development Home Category A
- ❑ Child Development Home Category B
- ❑ Child Development Home Category C
- ❑ Non-Registered Provider
- ❑ Exempt Facility
- ❑ In-Home Provider

RATES: The rates I charge for my child care services are (include <u>all</u> rates that you charge):

Your ½ day charges for basic and special needs child care services:

Infant/Toddler (up to 24 mo)			Preschool (24 mo to Kindergarten)			School age (K and up)		
Basic		**Special Needs**	**Basic**		**Special Needs**	**Basic**		**Special Needs**
$_____	½ Day	$_____	$_____	½ Day	$_____	$_____	½ Day	$_____

If you do not have a ½ day rate, please give us your daily or hourly rate.

$_____	Daily	$_____	$_____	Daily	$_____	$_____	Daily	$_____
$_____	Hourly	$_____	$_____	Hourly	$_____	$_____	Hourly	$_____

If you offer discount rates for second children or employees, or you have special rates for before and after school care, summer, etc., list these charges below:

_____

_____

_____

I understand the payment I will receive for providing child care for the Department of Human Services:

1. Will be based on a 5-hour unit of service.
2. Will be effective only during the effective period of this contract.
3. May be re-negotiated prior to the termination date, with the agreement of all parties.

CLIENT FEES:

I understand:

1. I am responsible for collecting all fees assessed to the client, as determined by the Department, directly from the client.
2. I will not bill any Child Care Assistance participant more than the required fee for the units of care provided, as stated on the participant's Notice of Decision.
3. I must maintain a record of all fees collected from clients and this record shall be available, upon request, for audit by the Department or its representatives.

BILLING AND PAYMENT:

I understand:

1. I must provide the service as authorized on the client Notice of Decision before submitting the invoice for payment.
2. At the end of each month I will submit an invoice to the Department only for those approved hours of child care services that are provided, using *Purchase of Service Provider Invoice*, form 470-0020, unless a locally-approved PROMISE JOBS form is provided to me.
3. At the end of each month, I will submit a *Child Care Assistance Attendance Sheet*, form, 470-3872, to the Department or a *PROMISE JOBS Child Care Attendance and Invoice*, form 470-3896, to PROMISE JOBS only for those approved hours of child care services that are provided.
4. I will complete a separate invoice for each county.
5. I cannot bill the Department or PROMISE JOBS more than what I charge other families for the same service.
6. I cannot request or accept additional payment from families, except for the client fees mentioned above.

PAYMENT FOR ABSENCES:

I understand:

1. I may bill for up to 4 days of absences per month (in accordance with the units approved for that day) when a child is scheduled to be in attendance that day.
2. I may not bill for a day of absence if this policy is not applied to private pay families.
3. Holidays may be paid ONLY when the child is scheduled to be in attendance and these days are charged to private pay families. Holidays are included in the 4 days maximum per month.

RECORD KEEPING AND AUDITING:

I understand:

1. I am responsible for keeping accurate records that document times and dates of care provided to each individual child funded by the Department or PROMISE JOBS.
2. These records must be kept for five (5) years.
3. If this case is selected for review or audit authorized by the Department, I will make these records immediately available, upon request, to substantiate the services I provided and received payment from Child Care Assistance funds.

PROTECTIVE CHILD CARE:

1. I understand that to provide protective child care, I must be a licensed or registered child care provider unless otherwise approved by the Department.
2. I shall develop and submit a written individual program plan, quarterly progress reports, and termination summary to the Department service worker when child care services are part of a child's protective service plan.
3. I will cooperate with all aspects of the child's/family's Departmental Case Permanency Plan.

SPECIAL NEEDS CHILD CARE:

1. Parents are responsible to provide the Department with written documentation that their child(ren) meet the definition of "special needs."
2. I understand that in order to receive "special needs" reimbursement rates, I must provide documentation to the Department that I am responding to a child's special needs with (but not limited to) adaptive equipment, more careful supervision, or special staff training.

OTHER PROVIDER REQUIREMENTS:

Non-Discrimination:

I will not discriminate because of race, color, religion, sex, creed, age, physical or mental disability, political belief, or national origin against any person seeking services.

Change Reporting:

I am responsible for reporting changes in my household members, address, phone number, etc. within 10 days of any change.

Abuse Reporting:

I understand that as a registered or licensed provider, I am a mandatory reporter regarding suspected child abuse of children in my care. I will report any suspected incidents of child abuse to the Department of Human Services immediately by phone and follow up with a written report. The number for reporting suspected child abuse is 800-362-2178.

I have a written policy stating how I will report suspected child abuse.

Confidentiality:

I will respect the privacy of the client and keep the client's relationship with the Department confidential. Personal information about the client may not be shared with anyone but the Department worker and the client. Failure to respect the client's privacy could result in cancellation of this agreement and legal sanctions.

Indemnity

I understand that I have the status of an independent contractor only and shall in no sense be an agent, employee, or servant of the state of Iowa, the Iowa Department of Human Services, any of its employees, or its clients. I will not hold the state of Iowa, the Iowa Department of Human Services, its employees, or its clients liable, as I shall be responsible for all activity in the delivery of services.

Drug-Free Environment

I will provide a drug-free child care environment in accordance with Executive Order Number 38.

Repayment:

I understand a referral may be made to an investigative unit when fraudulent practices are suspected. I understand that I may have to re-pay money received in error or as a result of fraudulent billing.

AGREEMENT TERMINATION:

Non-compliance with any of the provisions of this agreement may result in termination of this agreement upon ten days written notice from the Department. Both parties agree that except in case of emergencies such as illnesses, death, or fire, ten days advance notice shall be given to allow for the arrangement of alternate service provision for clients. Termination of this agreement may prevent you from making application to be a child care provider. The Department may also refuse to enter into subsequent agreements with you.

This agreement may also be terminated upon mutual agreement of the parties.

AGREEMENT RENEWAL:

This agreement must be renewed every two years from the effective date of this agreement. Failure to enter into a new agreement will result in termination.

AGREEMENT EXECUTION:

Name of Child Care Provider (please print)	Agreement No.
Signature of Child Care Provider	Date
Signature of Department Representative	Date

THIS AREA TO BE COMPLETED BY DHS/PROMISE JOBS WORKER ONLY

Payments made by the Department will be in accordance with the "Approved Unit Cost" as listed below		
Rates approved under this agreement:		**DHS USE ONLY**
AGE GROUP	**APPROVED UNIT COST**	**SERVICE CODE**
Infants (up to 24 months of age)		
Special Needs Infants (up to 24 months of age)		
Preschool		
Special Needs Preschool		
School Age		
Special Needs School Age		
Other Rates: (Second child, before and after school, summer, employee discount, etc.)		
Effective Date:	Termination Date:	

⇒ Human Services shall determine eligibility for services and shall authorize services if eligible. You may appeal through Department appeal procedures if you are dissatisfied with agency decisions.

Iowa Department of Human Services

CHILD CARE ASSISTANCE ATTENDANCE SHEET

Name of Parent/Custodian _____ Month _____ Year _____

	Name of child _____				Name of child _____				Name of child _____			
Day	**Time in**	**Time out**	**# of units**	✔ if Absent	**Time in**	**Time out**	**# of units**	✔ if Absent	**Time in**	**Time out**	**# of units**	✔ if Absent
1st		to				to				to		
2nd		to				to				to		
3rd		to				to				to		
4th		to				to				to		
5th		to				to				to		
6th		to				to				to		
7th		to				to				to		
8th		to				to				to		
9th		to				to				to		
10th		to				to				to		
11th		to				to				to		
12th		to				to				to		
13th		to				to				to		
14th		to				to				to		
15th		to				to				to		
16th		to				to				to		
17th		to				to				to		
18th		to				to				to		
19th		to				to				to		
20th		to				to				to		
21st		to				to				to		
22nd		to				to				to		
23rd		to				to				to		
24th		to				to				to		
25th		to				to				to		
26th		to				to				to		
27th		to				to				to		
28th		to				to				to		
29th		to				to				to		
30th		to				to				to		
31st		to				to				to		
	Total units				Total units				Total units			

I certify these hours of care are correct		
Signature of Parent/Custodian	Phone Number	Date

I certify these hours are correct			
Signature of Provider	Provider Number	Phone Number	Date

Please see instructions on back.

Iowa Department of Human Services

Child Care Provider Claim

1. Agreement No.: _____

2. Billing Period **Enter the time period you are billing for.** ____ - ____ - ____ (Month - Day - Year) thru ____ - ____ - ____ (Month - Day - Year)

3. Provider Name: _____
(Please print or type)

4. Provider Address: _____

5. Check if new address: ☐

6. City and State: _____ 7. Zip: _____

8. I certify that I provided services on the dates shown to the children listed below.

9. Choose type: ☐ Regular ☐ Protective

Provider's Signature

	10. Case Number	11. Child's Name Last First M.	12. If new, date service began	13. Service Code	14. Unit Cost	15. No. of Units	16. Total Cost	17. Co-Pay	18. Net Cost	For Local Office Use Only
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										
					19. TOTALS					

For DHS Use Only:

DHS Approval Signature: _____ Date: _____ Claim Number: _____

Date Returned to Provider: _____ Date Corrected Claim Received: _____

470-4466 (7/07) Copy 1: County Copy 2: Provider

Instructions

The Child Care Provider Claim is used to bill the Department of Human Services (DHS) for payment. Before you start, please read the instructions below. You will need a copy of the Notice of Decision for each family and your Child Care Assistance (CCA) Provider Agreement to complete the claim.

1. **Agreement Number:** Enter the 7-digit number from the top, right corner of the CCA Provider Agreement. This can also be found on Page 4 of the Provider Agreement.
2. **Billing Period:** Enter the beginning and ending dates of the billing period. Please include the month, date, and year. For example, enter: 07-01-07 thru 07-31-07. This should match the dates listed on the attendance sheet.
3. **Provider Name:** Enter the name exactly as it appears on your CCA Provider Agreement.
4. **Provider Address:** Enter your current address.
5. **Check if new address:** Check the box if you have a new mailing address.
6. **City and State:** Enter your city and state.
7. **Zip:** Enter your zip code.
8. **Provider's Signature:** Provider's signature (must be in ink).
9. **Choose type:** Regular is child care for work, school, medical incapacity, or job search. Protective is child care that has been authorized by a DHS social worker. This information can be found on Page 1 of the family's Notice of Decision.
10. **Case Number:** See the family's Notice of Decision for case numbers, which are located on the top, right corner. Example: 999999-99-99-9.
11. **Child's Name:** Enter the child's last and first name and middle initial exactly as it appears on Page 1 of the Notice of Decision.
12. **If new, date service began:** If the child started receiving services during the timeframe you are billing for, enter the date the service began. This information can be found on Page 1 of the family's Notice of Decision.
13. **Service Code:** See the CCA Provider Agreement on Page 4. The number is four digits.
14. **Unit Cost:** Enter the amount that you are being paid for each unit. See the rate section on Page 4 of the CCA Provider Agreement. A unit is any amount of time up to and including 5 hours in a 24-hour day. More than 5 up to 10 hours in a 24-hour day is 2 units.
15. **No. of Units:** Enter the total number of units you actually cared for the child during the billing period. You will use the number of units listed on the attendance sheet.
16. **Total Cost:** Multiply the unit cost (#14) by the number of units (#15). Put the answer here.
17. **Co-Pay:** This is the fee the parent pays to you. See the bullet on the Notice of Decision about fees. You will collect this amount from the parent and DHS will pay the rest of the bill. Multiply the unit fee on the Notice of Decision by the number of units you are billing for. Write the answer here. **This is a family fee, which means if you care for several children in the same family, the provider will only collect a fee for the child with the greatest number of units.**
18. **Net Cost:** Subtract the co-pay (#17) amount from the total cost (#16). This is the amount you will bill DHS.
19. **Totals:** Total the columns for total cost, co-pays and net cost.

If billing for daily/weekly units that are greater than what is approved on the Notice of Decision for the child, write a note on the attendance sheets to explain why.

Please attach attendance sheets to the invoice.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

July 2, 2007

Dear :

Our office has received your Child Care Provider Claim form.

In processing your claim, corrections have been made or need to be made so you can receive proper payment. Please see below.

We were able to process your claim for the following children. Payment has been submitted for .

We were able to process your claim. However, your claim had some errors on it. To ensure timely payments in the future, please see the highlighted sections of the claim to bill correctly in the future.

We were unable to process your claim, so I am returning it to you. Please complete the items checked below and return the claim so it can be processed.

- ☐ Provider must sign the form in ink
- ☐ A Child Care Attendance Sheet is required
- ☐ Provider and/or client must sign the attendance sheet

Your claim exceeded the number of approved units. You need to document the reason on the attendance sheet. If the client needs additional units, the client should discuss this with the caseworker. The number of units on the Notice of Decision has been paid.

We were unable to process your claim for the following reasons. Your claim form is attached. You must fill out a **new** claim form to correct these issues so your claim can be processed.

- ☐ Billing period for child care provided
- ☐ Agreement number
- ☐ Child's case number
- ☐ Child's name
- ☐ Service code
- ☐ Unit cost
- ☐ Co-pay
- ☐ Other:

cc: Claim attached